

NEW PATIENT ORDER FORM Continuous Glucose Monitoring

PATIENT SECTION

Patient Name		DOB
Phone	Alt Phone	
Shipping Address	City, State, Zip	

PHYSICIAN SECTION

<p>Step 1: Diagnosis Code (required)</p> <p><input type="checkbox"/> E10.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> E10.65 <input type="checkbox"/> E11.8 <input type="checkbox"/> E11.9 <input type="checkbox"/> Other: _____</p>
<p>Step 2: Prescriber's Prescription (check products prescribed)</p> <p><input type="checkbox"/> A9278 - Receiver (monitor); external, for use with interstitial continuous glucose monitoring system - 1 each</p> <p><input type="checkbox"/> A9277 - Transmitter; external, for use with interstitial continuous glucose monitoring system - 1 unit / 90 days</p> <p><input type="checkbox"/> A9276 - Sensor; disposable, for use with interstitial continuous glucose monitoring system - 1 unit = 1 day supply</p> <p> <u> 99 </u> - Length of need in months (99 = lifetime); default is 99 unless specified here: _____</p>
<p>Step 3: Statement of Medical Necessity (please answer all questions below)</p> <p>(A) Patient is currently in CGM therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(B) Patient has been seen within the last 6 months? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(C) Patient injects insulin at least 3x daily OR is currently on an insulin pump? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(D) Patient's insulin treatment regimen requires frequent adjustments based on CGM/BGM results? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p> ↳ If NO, have the patient's glucose levels remained in your established target range? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

I certify that (1) I am the treating physician of the patient identified in the section above, (2) the information contained herein is true, accurate, and complete to the best of my knowledge and according to my last visit with the patient, (3) I maintain and can provide medical records for the patient that substantiate the information completed above, the patient's ability to use, and medical necessity for a therapeutic continuous glucose monitor and/or related monthly supplies, (4) I agree to provide copies of the supporting medical records, as requested by Aptiva Medical and required by Medicare, and (5) the patient requires these products and I have not ordered these same products from another supplier for this patient during this service period. This document serves as a prescription/order and statement of medical necessity for the above-referenced patient.

Physician Name (print)	NPI #	Phone
Physician Address		Fax

**PRESCRIBER
SIGNATURE**

DATE